NEW YORK STATE DEPARTMENT OF HEALTH
INSTRUCTIONS FOR COMPLETING ATTACHMENT 2-W

Electronic filing is available for fulfilling Public Goods Pool (PGP), 1% Statewide Assessment, and Health Facility Cash Receipts Assessment reporting obligations. To file electronically, you must establish an electronic filing account and be assigned a secure password. A website has been established at www.hcrapools.org to facilitate this process.

FILING REPORTS ELECTRONICALLY

- All payors and third party administrators are required to file PGP reports electronically.
- Beginning January 1, 2005, designated providers of services subject to HCRA surcharges will be required to electronically submit PGP reports for periods on and after January 1, 2005. *This also applies to the 1% Statewide Assessment report filed by hospitals.*
- Beginning December 1, 2005, all Article 28 hospitals must file monthly Health Facility Cash Receipts Assessment reports.

All affected entities may voluntarily commence submitting reports electronically for periods prior to the dates mandated in law.

While electronic filing is designed to be very user friendly, a help desk has been established to aid those users requiring assistance. If you need general assistance or assistance in obtaining copies of the electronic filing screens and the electronic reporting certification forms, please contact the help desk at (315) 448-6994 or via e-mail at webpools@hcrapools.org.

Upon receipt of a fully completed Attachment 2-W, the Office of Pool Administration will assign a secure electronic filing user ID and password to your organization, which you will receive via return mail.

- **New Request/Revision to Existing Account**: Check the appropriate box. An entity requesting an initial account/password should check the *New Request* box; an entity that has an existing account and is advising the Department of a change to that account should check the *Revision to Existing Account* box.
- **Payor/Third Party Administrator/Provider Name:** Enter the name of the entity that will be submitting the reports electronically.
- **Federal Tax ID #:** Enter the federal employer tax identification number assigned to the entity named above.
- **Operating Certificate #: (For providers only):** Enter the Operating Certificate number assigned by the Department of Health to the entity named above.
- **MMIS # (For providers only):** Enter the MMIS # assigned by the Office of Medicaid Management to the entity named above.
- **Report(s) being filed electronically (check ALL applicable types):** Check all applicable types of reports that your entity will be filing electronically – Public Goods Pool, 1% Statewide Assessment *(for providers only)*, and/or Health Facility Cash Receipts Assessment *(for providers only*).
- **Signature:** Enter the signature of the Chief Executive/Financial Officer and/or Administrator of the entity named above.
- **Name (Please Print):** Print the name of the person signing above.
- **Title:** Enter the title of the person signing above.
- **Phone Number:** Enter the phone number of the person signing above.
- **Address/City/State/Zip Code:** Enter the address of the person signing above.
- **E-mail Address:** Enter the e-mail address of the person signing above.
- **Date:** Enter the date that this form is signed.

Note: ***All fields on this form are required to be accurately completed in order for your request to be processed.***

NEW YORK STATE DEPARTMENT OF HEALTH
ATTACHMENT 2-W
ELECTRONIC FILING USER ID AND PASSWORD APPLICATION

Note: All fields on this form are required to be accurately completed in order for your request to be processed.

□ **New Request** □ **Revision to Existing Account**

Payor/Third Party Administrator/Provider Name

_____

Federal Employer Identification # (EIN) _____

Operating Certificate # (*FOR PROVIDERS ONLY*) _____

MMIS # *(FOR PROVIDERS ONLY)* _____

Report(s) being filed electronically (check ALL that apply):

□ Public Goods Pool
□ 1% Statewide Assessment ***(for providers only)***
□ Health Facility Cash Receipts Assessment ***(for providers only)***

By signature below, the Chief Financial Officer or other duly authorized individual of the above named entity authorizes the Office of Pool Administration to assign a secure electronic filing user ID and password to the entity. This information will be mailed directly to the attention of the signer and must remain secured. It is the responsibility of the above named entity to ensure that this information is released only to those individuals requiring knowledge thereof.

Signature _____

Name (Please Print) _____

Title _____

Phone Number _____

Address _____

_____

City _____ **State** _____ **Zip Code** _____

E-Mail Address _____

Date _____

MAIL THIS ATTACHMENT TO:
Mr. Jerome Alaimo, Pool Administrator
Office of Pool Administration
Excellus BlueCross BlueShield, Central New York Region
P.O. Box 4757
Syracuse, NY 13221-4757